

PHA

FAMILY ADVOCATES UNITED

MEMBERSHIP FORM

For membership January 1–December 31, 2019

Make all checks payable to PHA

MAIL DUES AND DONATIONS TO:

Beverly Austin

PHA (Parent Hospital Association)

2683-17th Avenue

San Francisco, CA 94116

Check which type of membership below.

MEMBERSHIP DUES: \$25.00 Individual

\$30.00 Family (individuals with same address)

If donation included, please indicate the donation amount here: \$ _____

PROVIDE THE FOLLOWING INFORMATION FOR PHA (Please Print Clearly)

Name: _____

Address: _____ (Street)
_____ (City/State/Zip)

Check here if this is a new address since 2018

Telephone: _____ Email: _____

Would you consider being on the PHA Board: Yes No

Would you consider being on a PHA Committee: Yes No

Please check all that apply:

Family Member

Conservator

Former SDC Staff

Other: _____

PHA is a registered non-profit organization